

OFFICE OF PERSONNEL MANAGEMENT
Catastrophic Leave Bank Program
APPLICATION for BENEFITS

Please type or print legibly

Authorized by A.C.A. §§ 21-4-203, 21-4-214, 6-63-601 & 6-63-602

Case# _____

Instructions Complete this form to apply for Catastrophic Leave. Attach all appropriate documentation of the medical emergency. Include the Physician's Certification for Catastrophic Leave and the Catastrophic Leave Bank (CLB) Liability Agreement. Present forms to your supervisor			NOTE The award of Catastrophic Leave is dependent upon its availability within the Catastrophic Leave Bank. The program does not create any expectation or promise of continued employment.		
Part 1 – Application and Certification (To be completed by applicant employee or designee on his/her behalf).					
Patient Name (Last, First, Middle Initial)				Relationship to Employee	
If applicant has any qualifying family member(s) employed by the State, list their name(s) in the following sections					
Name of family member		Agency of family member		Social Security Number of family member	
Applicant's Name (Last, First, Middle Initial)				Applicant's Social Security Number	
Applicant's Personnel Number			Applicant's Position Number		
Applicant's Position Class Code	Applicant's Position Title			Pay Grade	Applicant's Hourly Rate of Pay
Agency/Institution		Work Phone Number	Home Phone		Birthday: Year/Month/Day
Retirement and Social Security/Social Security Disability Benefits					
<input type="checkbox"/> Yes <input type="checkbox"/> No I am eligible for Retirement or Social Security benefits. <input type="checkbox"/> Yes <input type="checkbox"/> No I have applied for Retirement. If yes, date applied: <input type="checkbox"/> Yes <input type="checkbox"/> No I have applied for Social Security/Social Security Disability. If yes, date applied:					
Applicant Certification: (Check ✓ all appropriate sections) I certify that: <input type="checkbox"/> 1. I have been affected by a medical emergency described on the attached Physician's Certification. <input type="checkbox"/> 2. I have, or will have, exhausted all Leave and Compensatory Time as of the date indicated. <input type="checkbox"/> 3. I expect to be absent from work without paid leave because of this medical emergency. <input type="checkbox"/> 4. I had at least 80 hours of combined sick and annual leave at the onset of this illness/injury, or I have attached the required documentation to receive an "extraordinary circumstance" waiver.				<input type="checkbox"/> 5. I have made application and am receiving Workers' Compensation Benefits in connection with this work-related condition. <input type="checkbox"/> 6. I have made application but am not receiving Workers' Compensation Benefits in connection with this work-related condition. <input type="checkbox"/> 7. I agree that any leave that I accrue while on Catastrophic Leave will be returned to the Catastrophic Leave Bank.	
Signature of Employee Receiving Catastrophic Leave or His/Her Designee			If Designee, state your relationship to Recipient		Date
Part II – Supervisory Verification (To be completed by Applicant's Supervisor.)					
Disciplinary Action for Leave Abuse During past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		Explain why this employee's leave has been exhausted. Be specific:			
Could this job be restructured temporarily to allow employee to return to work at an earlier date? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach revised job duties.					
Signature of Supervisor		Position Title		Phone Number	Date

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Employee/Applicant Name (Last, First, Middle Initial)	Social Security Number
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Part III – Personnel/Payroll Verification *To be completed by Agency Personnel/Payroll Officer.)*

Full-Time <input type="checkbox"/> Yes <input type="checkbox"/> No	Career Service Date	Latest Hire Date	Date Employee Would Go on LWOP	Case Number
Date Leave Exhausted – Attach Leave Calendar(s) <i>(Includes Annual, Sick, Holiday and Comp- verified by Timekeeper)</i>		Amount of Catastrophic Leave Requested	Duration Dates of Catastrophic Leave Request	
Date <div style="text-align: right;"><input type="checkbox"/> AM <input type="checkbox"/> PM</div>	Time	Last Day Worked	Total Hours Requested <i>In one (1) hour increments</i>	Beginning Date
Timekeeper's Name (Print)		Timekeeper's Signature	Phone Number	Projected Ending Date

WORKERS' COMPENSATION STATUS

Applied <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date
Amount of Workers' Compensation Weekly Benefits		Hourly Rate on Date of Accident		Hours of Catastrophic Leave Requested Weekly		
Date Workers' Compensation Commenced		Expected Duration		Date		

DISABILITY INSURANCE (FOR INSTITUTION EMPLOYEES ONLY)

Does institution provide Employee Disability Insurance? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Has employee filed for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Insurance begins/# of Months required for eligibility
Signature of Authorized Agency/Institution Representative	Position Title	Phone Number

Part IV – Catastrophic Leave Committee Review and Recommendation

Date Received	Date Reviewed	Dates of Duration of Approved Catastrophic Leave	
		Beginning Date	Projected Ending Date
APPLICATION APPROVED <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> *Extraordinary Circumstance Waiver of "80-hour" Rule	Total Hours Awarded	Total Dollar Value of Leave Received	INSTRUCTIONS <i>After review, recommendation and signature of Committee Chairperson, forward to Agency Director for final review and consideration of recommendation.</i>
Signature of CLB Committee Chairperson/Designee		Date	

Part V – Director's Review and Action

FINAL ACTION ☐ Approved ☐ Denied ☐ Concurred

Signature of Agency Director	Name of Agency	Date
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Return originals to:

OPM Catastrophic Leave Bank
 1509 West Seventh, Suite 201- DFA Building
 P.O. Box 3278
 Little Rock, AR 72203-3278

Part VI – Completed by CLB Record Keeper

Signature of CLB Record Keeper	Date
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**Institution may provide Disability Insurance at no cost to employee.*

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